Testimony of Dr. Richard Spoth

Before the
Committee on Education and the Workforce
Subcommittee on Education Reform

Hearing on
"Combating Methamphetamines through Prevention and Education"

November 17, 2005

Introduction

Mr. Chairman and members of the Subcommittee:

Thank you for inviting me to represent the Partnerships in Prevention Science Institute at Iowa State University in this critically important hearing on substance abuse prevention, with its special focus on methamphetamine abuse. As a research institute focused on prevention science, most of our work involves experimental studies that evaluate the outcomes of preventive interventions for youth and families. A unique aspect of our program of research is its model of school-community-university partnerships that implement the interventions and help sustain preventive efforts over time.

As I understand it, my task today is to respond to questions concerning our methamphetamine-related findings, how we approach methamphetamine and other types of substance abuse prevention, the evidence we have that our approach works in general, and how our approach can help to address the challenge of large-scale prevention impact. I am pleased to do this.

If I were to respond to this task with one sentence it would be: The effort to achieve larger-scale impact is very complex and challenging, but there has been much progress and some promising future directions are clear. Responses to the questions I have been asked to address will serve to highlight these points.

I. What are some illustrative methamphetamine-related results from our prevention work?

A. Short answer: Our randomized, controlled studies have shown intervention effects as long as 6½ years past the baseline assessment.

B. More detailed answer. To begin with some background information on our prevention work, our university motto "science with practice" captures the central theme of our Institute—promoting the application and translation of intervention science into community practices, to improve people's health and well-being.

Our Institute's mission is: "To conduct innovative research promoting capable and healthy youth, adults, families, and communities—through partnerships that integrate science with practice." Almost all of our work has been funded through grants from the National Institutes of Health—the National Institute of Mental Health, the National Institute of Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, with the lion's share of the funding coming from the latter. We also have received funding from the Center for Substance Abuse Prevention in the Services Administration for Mental Health and Substance Abuse.

In pursuit of this mission we have three primary goals.

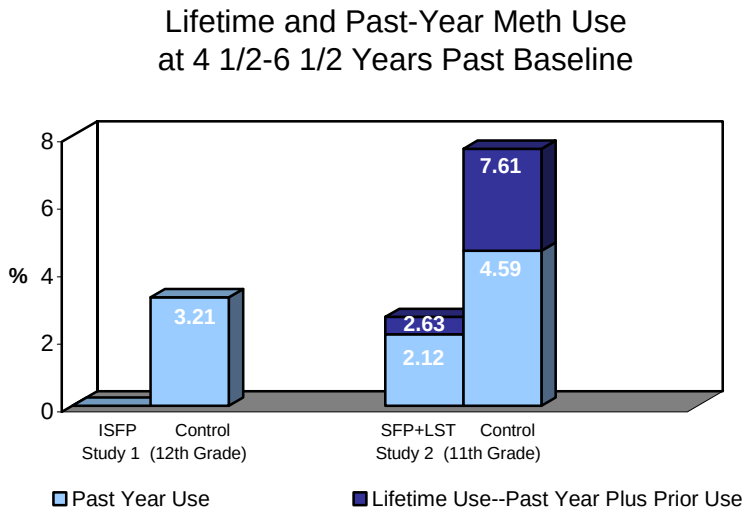
1. To study the effects of prevention and health promotion interventions for youth, adults, families, and communities;
2. To examine factors influencing youth, adult, and family involvement in evidence-based prevention, health promotion interventions, and intervention research projects; and
3. To evaluate the quality and sustainability of community-school-university partnerships and partnership networks, for widespread implementation of evidence-based prevention, positive youth development, and health promotion interventions.

To address our first goal we have designed and conducted a number of preventive intervention

outcome studies. Motivated by the findings of epidemiological research on increasing rates of methamphetamine use among adolescents, we added meth-specific outcome measures on two of our long-running preventive intervention studies. As you know, dramatic increases in use among adolescents have been seen; the 2003 prevalence rates are almost five times higher than the rates in 1992 (Johnston, O'Malley, Bachman, & Schulenberg, 2004; Oetting et al., 2000). Researchers have noted that adolescents in smaller towns and rural areas are particularly vulnerable to methamphetamine use, given the potentially powerful peer influences in rural environments and the historical appeal of stimulants to rural youth (Wermuth, 2000). The threat to rural Midwestern adolescents has been particularly acute (Rawson, Anglin, & Ling, 2002; Hall & Broderick, 1991; National Clearinghouse on Drug and Alcohol Information, 1997).

Our analyses of interventions delivered via community-university partnerships have revealed significant effects on lifetime or past-year methamphetamine use, up to 6.5 years after a baseline assessment. There also are some positive results from a third study, based on results from data collected at 1.5 years past baseline.

The following graph illustrates intervention effects on methamphetamine use (Spoth, Clair, Shin, & Redmond, 2005). Another way of describing the results from eleventh graders in Study 2 is as follows: eleventh graders who participated in both school-based and family-focused interventions reported 64% less lifetime meth use than students who did not participate in the programs.



Note: ISFP is the Iowa Strengthening Families Program; SFP + LST is the Strengthening Families Program (revised ISFP) plus Life Skills Training

II. What is our "science with practice" approach to prevention? A. Short answer: A science-driven partnership network linking public schools, Land Grant Universities and other resource systems.

B. More detailed answer: There are five key elements in our approach:

1. Linkage of existing, stable public education systems—ones that have infrastructure for optimal delivery and evaluation of interventions—with other service or resource systems;

2. Strategic partnerships with ongoing, hands-on technical assistance, including direct support from scientists or evaluators;

3. Evidence-based interventions for positive outcomes and economic benefits;

4. Quality implementation of evidence-based interventions for optimizing outcomes; and

5. Sustainability planning model for long-term local buy-in and funding.

1. Linkage of existing, stable public education systems—ones that have infrastructure for optimal delivery and evaluation of interventions—with other service or resource systems.

About 15 years ago we began the first in a series of large-scale experimental studies. At that point we saw tremendous potential in the linkage of public education intervention delivery systems—the State Land Grant University System and the Public School System—and linking them, in turn, with other community service delivery systems. In large measure, we saw the potential of their existing capacity for intervention delivery and for partnering in intervention research. To highlight this capacity, I will mention a few salient features of public education delivery systems.

The Cooperative Extension System is: the largest informal education system in the world; has over 3,150 agents in nearly every county that are highly educated; and has a "science with practice" orientation. The Public School System is a universal program delivery system reaching nearly all children; it has networks within each state for programming support and has increasing emphasis on accountability, as well as an empirical orientation.

For those of you who are less familiar with the Land Grant University and the Extension System, the Morrill Act of 1862 and the Hatch Act of 1887 established the U.S. Department of Agriculture and granted land in each state to support a college for teaching agriculture and engineering, as well as establishing agricultural experiment stations to conduct research. The Extension system soon followed, to carry the practical and relevant education to ordinary citizens through an extensive network of state, regional, and county extension offices in every U.S. state and territory. Its mission is: "To advance knowledge for agriculture, the environment, human health and well-being, and communities by supporting research, education, and extension

programs in the Land-Grant University System and other partner organizations." Extension is uniquely funded by a combination of federal, state, and county government monies.

Our framework is designed to seize the opportunity for intervention delivery in the existing public education systems. We do so by following Everett Rogers' (1995) "linking agents" concept from his *Diffusion of Innovation Theory*. That is, we emphasize the role of Land Grant University Extension agents who link public school personnel—school personnel who are aiming to implement tested, proven programs for their students and families—with systems of external services and resources, to promote health and well-being among youth and families.

In sum, linking public schools with the Land Grant Extension System and with other social and human services facilitates our efforts by helping PPSI to:

a. Deliver evidence-based interventions that have the greatest likelihood of producing favorable individual- and community-level outcomes;

b. Have the potential to reach every community across the U.S.;

c. Focus on community capacity-building and sustainability, so that chosen interventions will continue to be implemented over time; and

d. Develop and maintain ongoing partnerships, to which I will turn next.

2. Strategic partnerships with ongoing, hands-on technical assistance, including direct support from scientists or evaluators.

Over the 15 years our projects have entailed partnering with 106 public schools on a long-term basis and many others on a short-term basis. Over the course of the last 15 years, our partnership model has evolved. To begin, our evaluation of community-based interventions had an initial community-university partnership structure for collaborative research and program implementation. In a study called Project Family Trial I, we collaborated with local Extension

agents early in the process to help coordinate with local public school staff and program facilitators who, in turn, closely communicated with university partners to implement and evaluate our preventive interventions. This led to a second generation partnership structure employed in another earlier project, namely the “Capable Families and Youth” Project, where we learned how helpful it was to involve Extension staff who acted as linking agents at the state/regional level and assisted in coordinating our intensive program implementation and evaluation work across communities. The second generation partnership added a loosely-knit group of community residents who helped with organization and implementation of the intervention, but did not function as a team committed to long-term implementation (e.g., with regularly scheduled meetings and decision-making capabilities concerning implementation).

Inspired by the successes of the first two generations of partnership projects, we co-hosted a conference about Extension-assisted research projects (Spoth, 1998) that led to the design for the third generation of community partnerships. A salient, somewhat unique feature of the third generation is the relatively small size of the community partnerships, compared with so-called “big tent” community coalitions. These teams are designed to be very strategic, with focused intervention goals, and the responsibility to select interventions to implement locally (both family-focused and school-based) from an intervention menu.

The organizational structure for the third generation partnership model is outlined in Figure 1. Three teams form the model.

a. Local Strategic Teams:

-Are comprised of Extension System staff who serve as linking agents between public school system and other service or resource systems, such as health and social service provider

organizations, as well as other local community stakeholders, including parent groups, and youth groups;

-Meet regularly to plan activities/review progress;

-Select interventions from an intervention menu;

-Recruit participants for family-focused interventions;

-Hire and supervise program implementers;

-Handle all logistics involved with program implementation;

-Market the partnership model in their communities; and

-Locate resources for sustaining programs after grant funding ends.

A Prevention Coordinator Team:

-Includes prevention coordinators based in university outreach or Extension system;

-Provides support to local teams; and

-Provides ongoing, hands-on technical assistance, as well as documentation of ongoing partnership processes.

A University Prevention Team:

-Includes prevention scientists and Extension Program Directors;

-Provides resources and support to both local and prevention coordinating teams; and

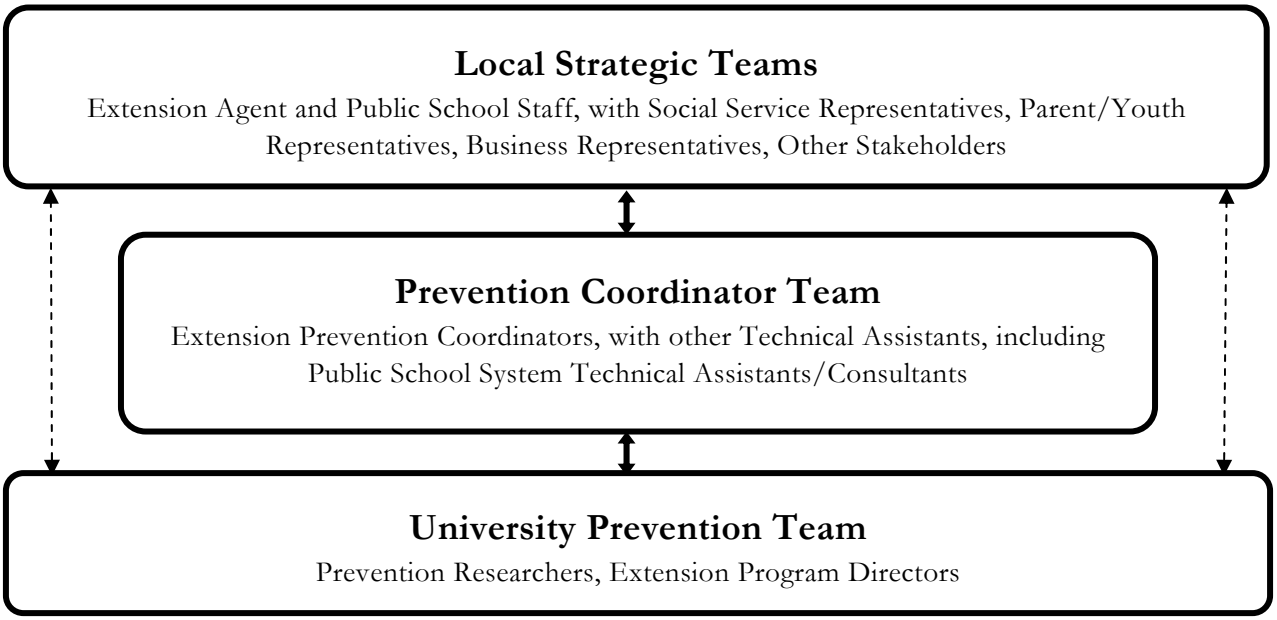
-Provides administrative oversight, offers input on data collection and analyses, and drafts project reports.

There are three phases of team development. During the first phase, team members are selected, regular meetings are scheduled, and the team begins to plan intervention work. While in the second “operations” phase, the teams learn about evidence-based interventions on the menu, consider their local community needs, select family-focused and school-based interventions,

recruit for the family interventions, and implement both types of interventions. During the third phase, teams develop plans for sustaining their team and their selected interventions; subsequently the team implements sustainability plans (including marketing their efforts and generating resources) and monitors its progress.

Organizational Structure for Community-School-University Partnership Model

(Across three phases of organization, operations, and sustainability)



Currently, we are implementing this model on a project called PROSPER (PROmoting School-community-university Partnerships to Enhance Resilience) conducted in collaboration with our colleagues at Pennsylvania State University.

3. Evidence-based interventions for positive outcomes and economic benefits.

The Society for Prevention Research has summarized standards for classifying interventions as evidence-based. By those standards, evidence-based interventions, or EBIs, are those interventions that: (a) emphasize a strong theory base; (b) clearly specify target populations and outcomes; (c) use psychometrically sound measurement of outcomes; and (d) are supported by

rigorous evaluation of outcomes, preferably randomized, controlled studies. The advantages of EBIs are:

a. Positive outcomes and economic benefits more likely for youth, families and others;

b. Better accountability—resources not used for ineffective programs;

c. Potentially better access to funding that is increasingly restricted to EBIs; and

d. Availability of materials, training and technical assistance.

Our focus has been on the partnership-based implementation of EBIs designed for general community populations. These EBIs aim to positively influence the two most important socializing environments for youth; namely, family and school. Extensive research has shown that key causal factors for substance abuse originate in the family and/or school environments, including parenting skills (e.g., parent-child communication, warmth, consistent discipline, and monitoring of child activities) and youth skills (e.g., social competence, decision-making, assertiveness, and substance refusal skills). EBIs included in Institute projects aim to influence these causal factors. Two examples follow.

A family-focused EBI we have evaluated extensively, the Strengthening Families Program: For Parents and Youth 10-14 (formerly the Iowa Strengthening Families Program), is based upon theory and empirical research (DeMarsh & Kumpfer, 1986; Kumpfer, Molgaard, & Spoth, 1996; Molgaard, Spoth, & Redmond, 2000). Goals include the enhancement of parental skills in nurturing, limit-setting, and communication, as well as a range of youth competencies, including peer resistance skills. Skills are taught to both parents and their young adolescent by trained facilitators during seven consecutive weekly sessions. Each session includes a separate, concurrent one-hour parent and youth skills-building curriculum, followed by a one-hour family curriculum during which parents and youth practice skills learned in their separate sessions.

Sessions use discussions, skill-building activities, videotapes that model positive behavior, and games designed to build skills and strengthen positive interactions among family members.

A school-based EBI we have evaluated, the Life Skills Training Program, was developed at Cornell University by Gilbert Botvin and his colleagues (Botvin, 1996, 2000), and is theory-based (Bandura, 1977; Jessor & Jessor, 1977). It consists of several lessons taught to adolescents during middle school. The primary programmatic goals are to promote skill development (e.g., social resistance, self-management, and general social skills) and to provide a knowledge base concerning the avoidance of substance use. Students are trained in the various skills through the use of interactive teaching techniques, including coaching, facilitating, role modeling, feedback, and reinforcement, plus homework exercises and out-of-class behavioral rehearsal.

It is very important to note that all of the EBIs we have implemented and evaluated aim to prevent all substance use and do not focus on any one substance in particular; however, we do subscribe to the idea that if there is a delay in initiation of alcohol use (the substance of choice among rural youth), that delay will help prevent the use or abuse of more serious substances, like methamphetamines.

4. Quality Implementation of evidence-based interventions for positive outcomes and economic benefits.

Many prevention efforts fail because of the common misperception that effective EBIs can be easily implemented, but the relevant literature indicates this is seldom the case (Backer, 2003; Fixen et al., 2005; Greenberg et al., 2000). Furthermore, numerous studies have shown that program implementation tends to drift away from the quality necessary to produce positive program outcomes. Implementing effective programs is difficult work, and requires careful, ongoing evaluation of the effectiveness of the implementation process. Our school-community-

university partnerships work hard to maintain a high quality of program implementation. To accomplish this goal, our partnerships engage in problem-solving, resource generation, and applying research findings to increase implementation effectiveness. Our data, from trained observers of the implementation process, consistently show high-quality implementation.

5. Sustainability planning model for long-term local buy-in and funding.

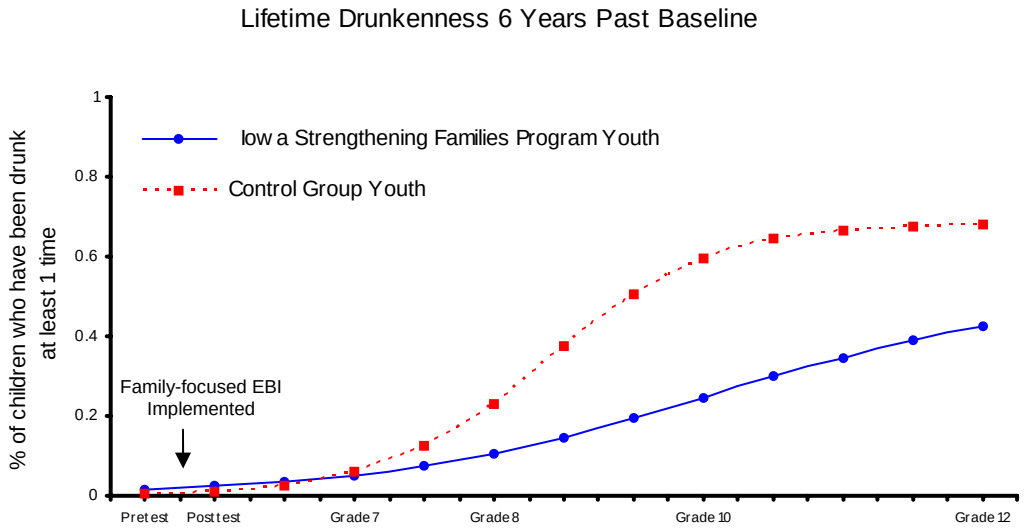
Research suggests that one of the major barriers to public health impact of EBIs is the failure to sustain programmatic efforts, particularly when the activities are initially funded through time-limited grants. Central to our partnership approach is a strategic sustainability planning model that begins early in the process. Our partnerships emphasize sustainability of both a well-functioning community team and of continued, quality implementation of EBIs, with emphasis on the generation of local financial and human resources. We are pleased that by the fourth year of our PROSPER project, sustainability planning has resulted in 100% of communities obtaining at least partial funding to continue programming.

III. What is the evidence that our approach works in general? A. Short answer: Six randomized, controlled studies and 11 supplemental studies over 15 years have shown effective partnership processes and positive long-term outcomes on substance use, problem behaviors, positive youth development, and family functioning. Again, we are grateful for our funding for this research from the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Mental Health, and the Center for Substance Abuse Prevention.

B. More detailed answer: As noted, over the past 15 years we have amassed substantial positive findings from a number of studies, in pursuit of our mission to promote healthy youth and families through school-community-university partnerships. The school-based and family-

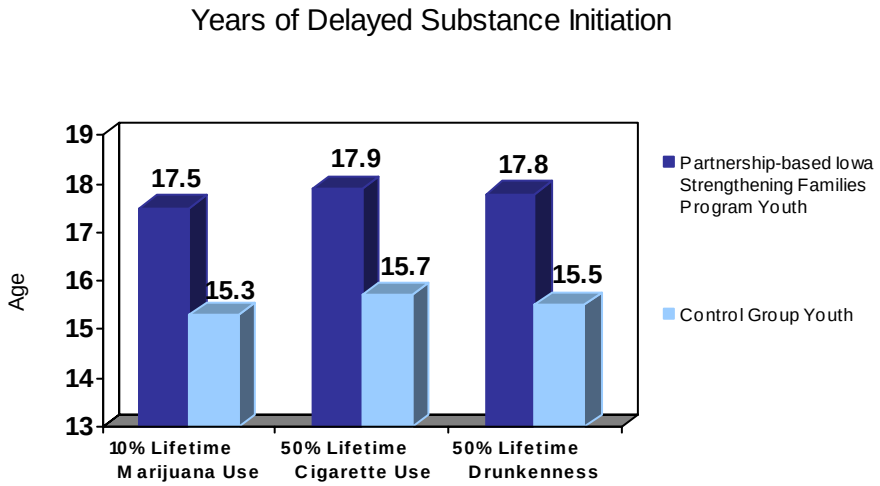
focused EBIs implemented have primarily focused on reduction of substance- and conduct-related problems. Benefits of EBI implementation extend beyond that, however, including positive effects on other mental health outcomes and mental health promotion (for example, enhanced parenting skills).

To illustrate positive longitudinal outcomes, in addition to those concerning methamphetamine use, in one of our studies we examined rates of substance initiation from 6th grade through 12th grade. The pattern of growth in initiation of substances of choice (for example, alcohol) follows a specific type of pattern, with an initially slow growth rate that rapidly increases and then returns to a slower growth rate in the latter years of high school. The estimated growth curves demonstrated statistically significant differences in the rate of growth for substance use for our family-focused EBI and control groups (see Figure below illustrating lifetime drunkenness). Other alcohol-related initiation measures (such as lifetime alcohol use) showed similar growth patterns (Spoth, Redmond, Shin, & Azevedo, 2004).

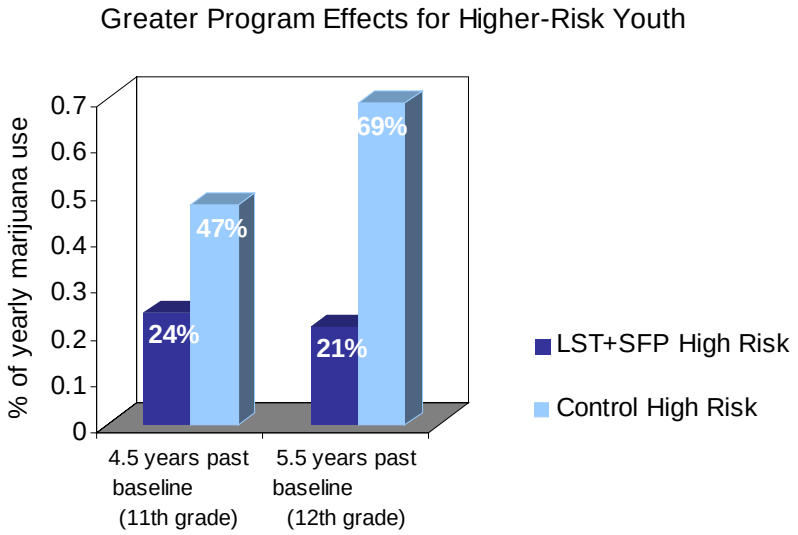


Other analyses have focused on the average age at which students in each experimental condition reach a certain rate of use on a range of lifetime use measures. Such analyses allow for a

comparison between the family-focused EBI group and the control group on the age at which a certain percentage of students (often 50%) have progressed from “no use” to initiation (e.g., begin smoking cigarettes). For example, if we look at when 50% of the students report ever being drunk, this occurred more than two years *later* in the EBI group than the control group (at age 17.8 vs. 15.5) (Spoth et al., 2004).



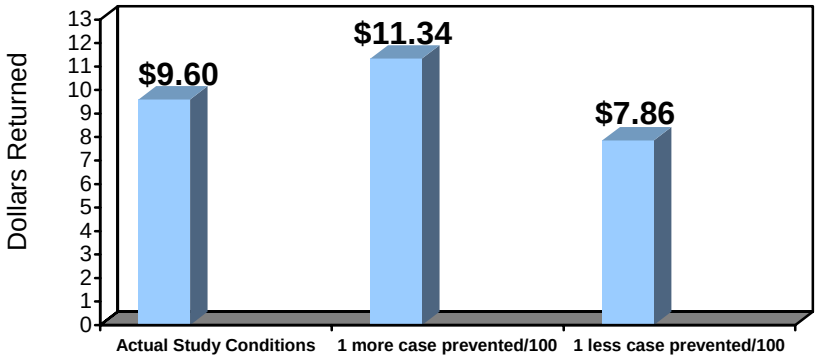
To determine whether EBIs are effective for high-risk students, effects on substance use for higher- versus lower-risk adolescents also are important to consider. Typically our interventions show that higher-risk youth and families benefit as much as lower-risk youth and families. In other cases, higher-risk youth benefit more. In the following example, youth are defined as higher risk if they already have used two or more substances—alcohol, cigarettes, marijuana—prior to implementation of the EBIs. The following graph illustrates strong intervention effects on yearly marijuana use for higher risk youth (Spoth, Guyll, & Day, 2002).



Note: ISFP is the Iowa Strengthening Families Program; SFP + LST is the Strengthening Families Program (revised ISFP) plus Life Skills Training.

Importantly, research at PPSI and that of others has demonstrated the economic benefits of these positive substance prevention outcomes. For example, to estimate benefit-cost ratios we used data on intervention effects on the delay of onset in alcohol use—along with data on (a) the relation between delayed onset of alcohol use in adolescence and alcohol use disorders in adulthood, and (b) the societal costs avoided by preventing adult alcohol use disorders. The next figure shows the estimated return for each dollar invested in the family-focused EBI under actual study conditions—an estimated return of $9.60 for each dollar invested. If additional positive outcomes, such as those on meth use, were factored into the equation, the return would be even greater. The next figure also shows the expected changes in the dollars returned when the number of adult alcohol use disorders prevented per 100 participants is increased and decreased by 1. The fact that the estimates remain well above zero suggests the robustness of the conclusion that the preventive intervention constituted a fiscally sound investment (Spoth, Guyll, & Day, 2002).

Family-focused EBI:
Benefit-cost Ratios Under Different Assumptions



Also, the principal conclusion of an exhaustive analysis conducted by the Washington State Institute for Public Policy found that some EBI youth programs are excellent investments. This report suggests that whether funds are federal, state, or local government, corporate or private, investing resources in proven, "blue chip" prevention stock is fiscally sound. The Washington State Institute for Public Policy (Aos, Phipps, Barnoski, & Lieb, 2001) estimated the comparative costs and taxpayer benefits for over 60 prevention programs. PPSI's PROSPER project has successfully implemented several of the programs reviewed in this report. Each program shows a net savings per child attending and a positive return on investment (see table below).

	Project ALERT	All Stars	Life Skills Training	Strengthening Families Program: For Parents and Youth 10-14
SAVINGS per child attending	$54	$120	$717	$5,805
RETURN on every $1 invested	$18.02	$3.43	$25.61	$7.82

Information on other outcomes, including those on youth skills, parenting skills, family functioning, and mental health outcomes can be found on our website (ppsi.iastate.edu).

IV. How can our approach help to address the challenges of larger-scale prevention impact?

A. Short answer: Achieving larger-scale impact requires confrontation with some major challenges; infrastructure support and resources to expand the partnership network are needed.

B. More detailed answer: Two of the major challenges to achieving community-level impact of preventive interventions on a large scale concern EBIs. First, we need to increase the number of EBIs to serve youth and their families in a culturally-competent way, across all settings and all stages of youth development. Second, and most importantly, we need effective delivery systems that sustain large-scale, quality implementation of these EBIs.

As concerns the first need, over the past two decades the field of prevention science has been successful in greatly expanding the number of EBIs. Nonetheless, although many reviews of EBIs have catalogued a large number of relevant interventions for youth, families and communities (e.g., Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002; Durlak & Wells, 1997; Eccles & Gootman, 2002; Gottfredson & Gottfredson, 2002; Greenberg, Domitrovich, & Bumbarger, 2000), most interventions implemented in real-world settings are not evidence-based. Further, more EBIs are required to meet the demands of all youth and families across rural, suburban, and urban settings.

Although noteworthy progress has been made in the development and testing of EBIs, limited headway has been made with the second challenge of sustained, large-scale, quality delivery of EBIs. The EBIs that exist are not widely disseminated, and those that are disseminated are often not implemented with quality, nor sustained over time (Ennett et al., 2003; Hallfors et al., 2002). Community partnerships are increasingly seen as a means of addressing this issue; however, we clearly need more research on the process of disseminating EBIs and scaling them up for greater

public health impact. We also need capacity-building for sustained quality implementation both within and across networks of communities (Spoth & Greenberg, 2005).

Addressing the challenge of effective, large-scale delivery will require some difficult systems-level changes in our primary EBI delivery system. As an example, some needed changes were highlighted in a survey of Extension staff. Survey results suggested five key areas in need of attention: (1) changing countervailing organizational values or beliefs, such as the belief that existing resources should primarily sustain traditional programming (e.g., traditional 4H youth programs); (2) competing reward structures for Extension staff, such as rewards for reporting high numbers of people attending meetings or those reached through newsletters, rather than for EBI results; (3) competing programmatic resource demands for already-existing programs, plus the need to see new sources of funding for existing programs, (i.e., as described by Extension staff: “I’m always dealing with what makes the phone ring and the door swing”); (4) increasing administrative support for collaboration on EBI implementation; and (5) increasing the number of champions for EBIs. It is expected that following the model diffusion process described subsequently would greatly facilitate these types of changes, over time.

Our partnership model is designed for dissemination to states across the entire U.S. Indeed, a large number of states already have expressed interest in adopting our partnership model. Scaling up for widespread dissemination requires:

-A set of state-focused replication plans to bring our partnership model to additional states, to address a range of youth development and problem-behavior areas where EBIs could help.

-The development of infrastructure to support a network for new partnerships, including informational materials, technical assistance, and a structure for partnership networking.

We believe that it will be important to follow a diffusion of innovation approach (Rogers, 1995), starting with “early adopter” states that demonstrate readiness for successful model implementation, as capacity is built for supporting additional states and communities that subsequently adopt the partnership model. As the early adopter states show positive results from their pilot projects, the level of interest in adopting the model, and in developing the capacity to respond to that interest, would allow the partnership model to spread and the partnership network to develop.

In other words, a sequence would unfold in which, first, the model will be expanded to additional communities beyond the pilot communities within the early adopter states. Then, the dissemination model will be expanded into additional states, involving gradually increasing numbers of communities beyond the pilot communities. In addition, the model will be applied to positive youth development and reduction of problem behaviors beyond substance abuse and conduct problem prevention. For example, we are working with obesity prevention researchers to adapt the model to that area. The partnership model is a general framework that is not restricted to substance prevention interventions—although, to date, the evidence for model effectiveness has been focused on substance abuse and conduct problem prevention.

1. State-focused replication and expansion plans.

To start, replication efforts in additional states will focus on implementing and testing EBIs preventing substance abuse and conduct problems, along with related positive youth development for middle school youth. In all cases, replication projects will build upon existing partnership-related efforts within the state (such as Community Anti-Drug Coalitions of America, Communities that Care Coalitions). To ensure success of the replication effort we will consider the readiness of states and communities to implement the partnership model. This will

include readiness assessments that evaluate interest in the project among opinion leaders within Extension and public education, as well as possibilities of partnering with prevention scientists and evaluators in the state. In addition, prospective communities that might be involved would need to demonstrate commitment to prevention, the resources available for the community effort, and evidence of relevant past collaboration.

Each statewide replication effort will begin with the formation of a steering committee, with representation from Extension, prevention research scientists, the state Department of Education, and other stakeholders or potential funders. The steering committee will review interest in replication at the state and community levels; subsequently, the committee will make a decision concerning the level of interest and the presence of funding to drive a replication effort under their guidance, with support from the national partnership network infrastructure.

If the decision is made to proceed in prospective replication states, plans will be made for state team development, supportive infrastructure, and community pilot studies (ideally, three or four communities in each state). State leadership will be provided by the steering committee and a prevention coordinator, along with local leadership supervising a community team. Each community pilot will include funding for an evaluation component to inform project improvements as it proceeds and to contribute to a knowledge-base about the partnership model.

2. Partnerships Infrastructure Development and Research.

Necessary national infrastructure to support the network of partnerships will include:

a. an information dissemination component—including a website;

b. technical assistance for each replication state;

c. partnership manuals and handbooks;

d. an information management system; and

e. a national-level steering committee, including representatives from both the replication states and the initiating states.

The partnership model in each replication state will be patterned after the existing PROSPER model currently being implemented in Iowa and Pennsylvania.

There are limited financial resources and capacity for partnership model diffusion and network development. With the probable reduction to the U.S. DOE Safe and Drug Free Schools funding, the pool of resources for substance prevention programming by community partnerships will be diminished. Given the increasing emphasis placed on demonstrating program effectiveness, it is worth restating that, based on 15 years of PPSI research, a high return on investment for substance abuse prevention would likely result when community partnerships implement EBIs with high quality, in conjunction with university partners that have the capacity to provide ongoing technical assistance and program evaluation.

From the perspective of the above described approach, the most effective use of federal dollars for substance abuse prevention requires: (1) effective linkages among key intervention delivery and evaluation systems; (2) strategic school-community- university partnerships; (3) the use of EBIs; (4) implementation with fidelity; and (5) sustainability planning. As an example of legislation that supports this type of approach, the HeLP America Act (HAA) is designed to have a positive impact on public mental health and well-being. To accomplish this goal, the HAA emphasizes the aforementioned key elements, including the highest caliber of programs, delivered with high quality by community-based partnerships. The HAA also recommends that strong emphases be placed on both sustaining the program after initial funding ends and on the importance of a high-quality programmatic evaluation to accomplish this goal. In other words,

the HAA is one step in the direction of what clearly is needed in a steady and substantial long-term stream of funding.

In short, we believe an investment in the type of partnership approach outlined above would: (a) save money; (b) reduce substance use-related problems; and (c) improve youth and family health and well-being, making a “real world” difference.

Again, I thank you for this opportunity and I would be happy to answer any questions you may have.